Enter Your Practice Name Here

herein after referred to as "Provider"

Patient's General and Emergency Contact Information Sheet

Please complete this form by indicating a check mark in each section that would be an acceptable manner in which our practice can contact you.

☐ In case of an emergency I authorize Provider to contact _____

at (_____) _____-_____. My relationship to this contact is: _____

I wish to be contacted by Provider in the following manner (please check all areas that would be an acceptable manner for Provider can contact you):

☐ Please contact me on my home telephone: (_____) _____-_____

- ☐ Provider can leave their name and phone number only when they call.
- ☐ Provider can leave a detailed message when they call.

☐ Please contact me on my cellular phone: (_____) _____-_____

- ☐ Provider can leave their name and phone number only when they call.
- ☐ Provider can leave a detailed message when they call.

☐ Please contact me at work: (_____) _____-_____

- ☐ Provider can leave their name and phone number only when they call.
- ☐ Provider can leave a detailed message when they call.

☐ Provider can mail or email me information such as appointment reminders, and future clinical sponsored programs.

- ☐ Provider can mail information to my home address.
- ☐ Provider can mail information to my work address.
- ☐ Provider cannot mail information to my home or work address, except statements of my account.
- ☐ Provider may send me email messages such as appointment reminders at the following email address: _____. (Leave blank if you do not wish to be contacted via email.)

☐ I herby give permission to Provider, to release medical information pertinent only to my current medical condition to: _____ relationship: _____

_____	_____	_____
Patient's Name (Please Print)	Signature of Patient, Parent or Legal Guardian	Date

Enter your Practice name, address, and phone number here.